Cleanliness in hospitals means more than just maintaining a clean and safe environment. It makes a statement to patients and visitors about the attitudes of staff, managers and the trust board. It reflects attention to detail, the level of care and the way the hospital is organised and run.

This guide will help you to increase your knowledge about the importance of cleaning and the role of nurses in keeping the patient environment clean and safe. While it discusses issues related to the NHS and ward environments, the principles can be applied equally to the independent sector and to most areas of primary care. Nurses are central to a good environment for care and cleanliness should be high on every nurse's agenda.

This guide has been based on the recently-issued *Healthcare Cleaning Manual* (DoH 2004a), which will shortly be available on every hospital ward. The manual is a comprehensive guide to the 'how' of cleaning. It is aimed primarily at those who are directly involved in cleaning, although the principles it contains are important for everyone. For many nurses the manual is too detailed for everyday use, hence this abridged version.

The *Healthcare Cleaning Manual* (DoH 2004a) will assist housekeepers and nursing staff who supervise cleaning standards to make judgments about quality and outcomes. It contains advice and guidance concerning the general cleaning of premises and equipment, an overview of infection control issues, and a section on cleaning patient care equipment – tasks normally undertaken by nursing staff. Patients rightly expect everything to be clean; not just the floors, surfaces, furniture and toilets normally cleaned by cleaning-service departments, but the intravenous-bag stands, wheelchairs, bed frames and blood-pressure equipment used in their treatment and care. These important items often slip through the 'cleaning net'. Nurses have a duty of care to their patients to ensure that equipment is clean and fit for purpose before use.

Some of the legislation and documentation referred to in this guide is specific to England, but the principles expressed are equally relevant to all parts of the UK.

**The patients' view**

Patients rate cleanliness very highly. They are entitled, and expect, to be treated and cared for in pleasant, clean, tidy and safe environments. There is also increasing evidence that the quality of the physical environment has an impact on clinical outcomes for patients (Lawson et al 2003, Ulrich 2001). Staff behaviour that supports high standards of cleanliness is vital for addressing and preventing healthcare associated infections (HCAIs). For trusts, cleanliness is an important performance indicator that can influence whether they can apply for foundation trust status.

The Chief Nursing Officer for England has recently convened a group of nursing and facilities staff to consider issues of cleanliness and infection control. This group has endorsed the principle of teamwork as central to delivering high standards of cleanliness.
cleaner, safer environments. Modern matrons are taking the lead in making sure that cleanliness standards on their wards meet patients' expectations, and are increasingly able to intervene and resolve problems if they exist. The development of the housekeeper as part of the ward team, responsible for co-ordinating facilities services at ward level, means there is now a direct link between the modern matron, ward manager and the cleaning team, thereby providing a seamless service between the various providers of care in the trust (Box 1).

This is, however, not always the case, and many nurses have limited knowledge about the actual processes and mechanisms of hospital cleanliness. Some also feel uncomfortable with the responsibility. When cleaners are on short-term contracts, or where there is a fast turnover in employment, it can be hard for nurses to set and maintain standards or to instill into everyone the importance of taking pride in the ward environment.

Delivering a cleaner NHS
Since 2000, standards of cleanliness throughout the NHS have been raised by:

- Patient environment action teams, both at national and local levels, using their unannounced inspections, reporting and feedback to local managers.
- New funding from central government and local trusts for cleaning services.
- The inclusion of cleanliness as part of the Planning and Priorities Framework 2003-2006.
- The inclusion of hospital cleanliness as one of the nine ‘key’ Star Ratings Indicators.
- The nomination of a trust executive to take overall responsibility for reporting on cleanliness issues to trust boards.
- The National Standards of Cleanliness (DoH 2001) that enabled hospital to measure ‘technical cleanliness’ and make comparisons.
- The repositioning of cleanliness issues back into the forefront of thinking in terms of the overall patient experience.

Cleaning programmes must be appropriately focused, effectively resourced and should consistently deliver high-quality services that are well regarded by patients. Trusts are encouraged to have local arrangements for cleaning in the form of service level agreements (SLAs) for departments and wards throughout the hospital. Each SLA should set out the range of services to be provided, the times and frequencies at which cleaning will take place, who is responsible for providing them, who is responsible for making judgements about outcomes, and how modern matrons can get things fixed and changed when required.

At an operational level, trusts should ensure that each staff member who is employed on cleaning duties, or is associated with cleaning services, has the right level of training, the appropriate equipment, knows what needs cleaning and how to clean – including the right cleaning materials to use – and is sufficiently supervised.
Box 1. The impact of housekeepers on cleanliness standards

Many trusts have seen dramatic improvements in standards of cleanliness since they introduced housekeepers. Because housekeepers work as a part of the ward team, reporting on a day-to-day basis to the ward sister, they develop a sense of ownership and involvement that means they can deliver real and visible improvements. For example:

- Chesterfield & North Derbyshire Royal Hospital NHS Trust has shown a 33 per cent improvement in patient-equipment cleaning scores and a 2 per cent improvement in overall cleaning scores.
- Mid Cheshire Hospitals NHS Trust has shown improvements in National Standards of Cleanliness (DoH 2001) scores from 25 per cent up to 100 per cent in some areas.
- Oxford Radcliffe NHS Trust has lifted cleaning standards by 30 per cent.
- East Somerset Hospitals NHS Trust has improved cleanliness standards from 60 per cent to 97 per cent.
- Leighton Hospital, in Cheshire, has recorded National Standards of Cleanliness (DoH 2001) scores increasing from 25 per cent up to 80 per cent.
- Airedale Hospital NHS Trust Patient Environment Action Team (PEAT) scores, which had dropped from green to amber, have now gone back to green.
- Eastbourne Hospital has recorded an increase in patient satisfaction with the standard of cleaning of the bathroom and toilet facilities from 100 per cent dissatisfied to 80 per cent satisfied.
- Newham Healthcare NHS Trust figures show that patients are now 90 per cent satisfied with cleanliness – a 20 per cent rise on the previous year.
- Oxford Radcliffe Hospitals NHS Trust ward housekeepers effectively police waste segregation at ward level, and evidence has been recorded of a 30 per cent reduction in costs associated with waste disposal through better segregation and recycling.

More information on introducing housekeepers is available from the NHS Estates website (www.nhsestates.gov.uk). Locally, support can be found via Basic Care Networks (BCNs) that operate in each Strategic Health Authority (SHA) and help to spread good practice across trusts. The name of your local BCN lead is available from the same website, or by calling the Patient Environment Team on 0113 254 7000.
executives, nurses, doctors, cleaners and housekeepers, as well as professional groups such as the Infection Control Nurses Association, Association of Domestic Managers, British Institute of Cleaning Science, Hospital Caterers Association and the Health Facilities Management Association. With so many people having a vested interest in a cleaner NHS, standards should be readily assured.

At ward level, assuming that nurses and facilities staff understand their role in providing clean environments and that resources and training are managed effectively, hospitals and other healthcare premises will offer:

1. A clean, comfortable and safe environment for patients, clients, visitors, staff and members of the general public.
2. Increased patient confidence in local healthcare settings in relation to environmental hygiene and the organisational commitment to reduce the incidence of healthcare-associated infection.
3. The opportunity to improve cleanliness standards in terms of the National Standards of Cleanliness (DoH 2001) and PEATs.

Managing cleaning contracts and monitoring standards

Modern matrons and ward sisters/charge nurses are jointly responsible for the quality of the patients' environment. They should be involved in setting standards for cleanliness, irrespective of who provides the cleaning service. Performance at ward level is often monitored by housekeepers, who are in a position to help modern matrons and ward sisters to liaise with cleaning staff and contractors.

Nurses have real power and should have the confidence to use it; this means acting early before there are major problems. If a matron considers that standards of ward cleanliness service are not being maintained, she or he has the right and obligation to pursue the following actions:

1. The ward sister or charge nurse should attempt to resolve any problems with the local staff and supervisors.
2. If standards do not improve, she or he should raise those concerns with the matron, who should then, in turn, notify the hotel service manager of the failure and set a timeframe for improvement.
3. If standards remain inadequate, the matron should write formally to the chief executive requesting that payment be withheld, either from the in-house service or the external contractor.
4. The chief executive should withhold payment and commence an arbitration process.
5. If the matron remains unhappy with standards following arbitration, the contract should be concluded and an alternative service organised.

Withholding payment to a contractor involves a legal process and should only occur if there has been a breach of contract by the supplier. Existing and future contracts for cleaning services should contain clauses about action for breach of contract and consider the possibility that a contractor may be failing to meet standards in just a single ward. Care must be taken to ensure that these clauses do not favour either in-house or external service providers (Figure 1).
Cleaning service and outcomes

Ward sister or modern matron, contract manager and domestic services manager

Ward sister to discuss with cleaning team

Matron to discuss with manager – specify correct timescale

Report to board nominee and chief executive

Payment withheld and arbitration commenced

Determine contract

Cleaning carried out

Ward clean enough?

Continue to monitor

YES

NO

YES

NO

YES

NO

YES

NO

Figure 1. Flow chart indicating the process for withholding payment from cleaning services
Colour code for hygiene

At the least, nurses need to understand whether cleaning is being appropriately maintained. Colour-coding systems for cleaning services, cleaning materials, equipment and training programmes already exist in some trusts and help to create a common understanding.

There are currently a number of different coding systems in use and it will take time to move towards a universally common position. A national colour code has been proposed by NHS Estates in The Healthcare Cleaning Manual (DoH 2004a). This is set out in Figure 2. However all nurses should be familiar with, and adhere to, their local colour coding and other cleaning policies. Trusts should consider this colour-coding standard in the light of their current positions, policies and guidance from Infection Control Teams. The impact of proposing a national standard colour-code system is being reviewed by NHS Estates in terms of cost, training implications and the impact on suppliers.

Infection control

Good practice measures

The essence of good cleaning is not only that things look clean, but that they are ‘technically’ clean. All those using the healthcare premises have a right to assume that the environment is one in which hazards are minimised. They also have a right, where appropriate, to receive any necessary information to enable them to safeguard themselves from disease.

8 nursing standard july 14/vol18/no44/2004
It is difficult to determine exactly how many HCAIs are transmitted via dirty environments or equipment, and no single measure will reduce the incidence of HCAI-related problems. It is apparent, however, that members of the general public perceive cleaning to be an important front-line response. Many organisms, including Methicillin-resistant Staphylococcus aureus (MRSA), live in dust. Removing dust is, therefore, an obvious and sensible way of reducing MRSA in the environment. Checking for dust is a simple and effective way of beginning to set and maintain standards. This includes checking at high levels (for example, curtain rails) as well as in difficult-to-clean places (for example, behind radiators). Maintaining this in partnership with cleaning supervisors will help to develop a sense of teamwork and common ownership that is vitally important in delivering a clean environment.

Trusts already have detailed infection control policies and procedures in place, with associated operating instructions to ensure that risks are minimised, contained and managed appropriately. The information provided below is taken directly from the *Healthcare Cleaning Manual* (DoH 2004a). However, in all cases, responsibility for such matters rests with the trust board, and local policies take precedence.

### Terminal cleaning

When a room has been used to care for a patient with an infection, it will need to be deep-cleaned before the next patient is admitted. This will include cleaning the beds and other furniture. The *Healthcare Cleaning Manual* (DoH 2004a) provides details, but what matters is that this process is carried out promptly and thoroughly. Nurses may need to work closely with their facilities management departments to define an approach that integrates appropriate cleaning with other aspects of the discharge and admissions processes.

### Classification of infection risk

It is important to understand the level of risk involved with all cleaning processes so that appropriate measures can be built into the cleaning protocol. Table 1 provides classification for the risk of infection associated with the decontamination of patient equipment.

### Infection control measures

1. **Colour coding** – the benefits from a common understanding and deployment of such a system to reduce cross-contamination are self-evident. A review is underway to establish the impact of introducing a national system.
2. **Protective gloves** – gloves should be worn for all cleaning tasks. Gloves must be suitable for the purpose of use and comply with colour-coding systems or be disposable. Latex gloves should not be used. Clinical gloves are not suitable for use by domestic staff. Trust policies will specify which type of glove should be worn for particular tasks or processes. The use of gloves does not replace the need for appropriate hand washing.
3. **Disposable plastic aprons** – disposable plastic aprons must be worn as a waterproof barrier if contamination of clothing is likely to occur. In some trusts these are colour coded. Overalls
or waterproof footwear may be indicated by a
Control of Substances Hazardous to Health
(COSHH) risk assessment if contamination by
large amounts of fluid is anticipated.

iv) Safety goggles, visors and respiratory pro-
tective equipment: safety goggles and visors
must be worn to protect the eyes, nose and
mouth during any procedure where there is a
risk of fluid splashing into the face. The type
of protective clothing worn should be based
on the assessed risk of exposure to harmful
substances (for example, chemicals or blood
and body substances). Respiratory protective
equipment should be used if there is a risk of
inhalation of harmful substances.

v) Accidental exposure to blood or body fluids:
all healthcare workers should be informed and
educated about the possible risks from expo-
sure to blood-borne viruses and should be
aware of the importance of seeking urgent
advice following any needlestick injury or other
possible exposure. Detailed guidance on man-
gement of blood exposure incidents can be
found in Guidance for Clinical Healthcare
Workers: Protection against Infection with

Table 1. Classification for the risk of infection associated with the
decommission of patient equipment

<table>
<thead>
<tr>
<th>Risk Application</th>
<th>Recommendation</th>
</tr>
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<tbody>
<tr>
<td>High</td>
<td>Items in close contact with broken skin or mucous membranes. Sterilisation is required.</td>
</tr>
<tr>
<td>Significant</td>
<td>Items in contact with intact skin, sterilisation or disinfection is required, particularly after use on infected patients. Cleaning may be acceptable in some agreed situations.</td>
</tr>
<tr>
<td>Low</td>
<td>Items in contact with healthy skin or not in contact with the patient. Cleaning is sufficient.</td>
</tr>
</tbody>
</table>


Where exposure to material known or suspected to be infected with HIV or hepatitis B occurs, appropriate post-exposure prophylaxis (PEP) should be offered. Further guidance on PEP following HIV exposure can be found in HIV Post-Exposure Prophylaxis: Guidance from the UK Chief Medical Officers’ Expert Advisory Group (DoH 2004b).

Inoculation injuries
For example, needlestick, other sharp injuries, bites, scratches and splashes to broken skin require immediate action:

I Wash the area with soap and running water and encourage the injury to bleed freely. Do not suck the wound.
I Apply a waterproof dressing.
I Report the incident to your manager and contact the occupational health or accident and emergency department for further advice (refer to local policy).

Intact-skin exposure
Wash immediately with hot, soapy water.

Non-intact skin exposure
Follow the steps above as for inoculation injury.

Mucous membrane exposure
Mouth: wash out with copious amounts of water; eyes: irrigate immediately with water or sterile saline from an eye station. Both incidents should be reported in the same way as an inoculation injury.

vi) Safe disposal of sharps:
I Discard needles and syringes as one unit into the sharps-container that conforms to UN3291 and BS7320 standards at the point of use.
I Never attempt to re-sheath, bend or break needles or overfill the sharps-container.
I Seal the container correctly and label when two thirds full.
I Always use the handle when carrying a sharps-container, holding it away from the body.
I Store in the designated disposal area.
I Never attempt to decant contents of small sharps-containers into larger containers.

vii) Spillages: all spillages of blood and body substances must be dealt with immediately by an appropriate member of staff and in accordance with trust policy. Staff must be appropriately trained to deal with spillages safely and have access to the necessary equipment and procedures required for spillage management as detailed in trust policies or guidance.

viii) Spillages of sharps:
I Sharps, such as small quantities of broken glass, drug vials, used needles, razors, blades, must be carefully disposed of into a sharps-container using forceps or tweezers.
I If a sharp object is found, remove the item carefully and place into a sharps-container.
I Do not physically handle the sharp if a dustpan and piece of cardboard or plastic can be used as an alternative.

ix) Waste disposal – the handling of waste must be undertaken with care and separated into different categories in accordance with local trust policies and procedures. Any waste that is contaminated with blood or body fluids should be disposed of as ‘clinical waste’. All clinical waste must be disposed of in appropriate...
containers (e.g., sharps containers, yellow clinical-waste bags) and labelled according to department of origin. Examples of clinical waste include gloves, aprons, dressings, catheter bags and anything that has come into contact with blood or body substances. Bags must be tied securely and not be overfilled, then stored in the designated disposal area before disposal. Sharps containers should not be over-filled. Some clinical waste is also classified as ‘special waste’ and subject to special controls. This includes discarded syringes, drugs and other pharmaceutical products. Used sharps and fully discharged syringes may still contain or be contaminated with prescription-only medicines and will therefore be special waste. Non-clinical domestic waste must be disposed of in black bags.

Segregation of linen and waste: contaminated linen or linen used by patients with specific infections must be segregated to protect staff involved in transportation or handling, and segregation methods/linen-bagging guidance will be part of trust policy and guidance. HSB (95) 18 remains extant.

Decontamination of patient equipment: the decontamination process is required to make patient equipment safe for staff members to handle and safe for patient use. Local policies will indicate nominated staff groups for the decontamination of clinical equipment, for example, nursing, housekeeping or domestic staff. Whoever is responsible for clinical equipment should ensure that local decontamination policies are followed. Hospitality/domestic services staff must make sure that items of equipment used in the cleaning process are adequately decontaminated when visibly dirty and/or according to trust policy. Equipment must be cleaned prior to leaving the ward/department/clinic for loan, service or repair. Any item that is described as disposable or for single-use must not be re-used or shared. Single-use items are defined by the strike-out symbol shown in Figure 3.

Hand washing and skin care: good hand hygiene remains the most effective method of preventing spread of infection between patients and also in preventing the acquisition of infection by staff. Hands can be cleaned with an alcohol-hand rub unless visibly soiled. Cuts and abrasions on the hands and forearms should be covered with waterproof dressings.
Blue waterproof dressings should be worn by staff who handle food.

Hand washing is important for maintaining the integrity of skin. Staff with extensive exposed lesions such as eczema or psoriasis should seek occupational health advice. Use of emollient hand cream should be encouraged to protect the skin from the drying effects of regular hand decontamination. Communal pots or tubes of hand products should not be used due to the risk of cross-infection. Staff should keep nails short and clean, not wear false nails and remove all nail varnish when at work.

Hands must be decontaminated:
- When visibly dirty or soiled.
- Between different types of cleaning procedures.

Hands should also be washed before:
- Starting work, going for a break, and leaving for home.
- Any cleaning operation.
- Preparing or handling of food and drinks and/or when handling any other related catering equipment.
- Entering and leaving an isolation area.

Hands should be washed after:
- Handling any item that is soiled.
- Handling linen, bedding and waste.
- Removing protective clothing, including gloves.
- Any cleaning operation.
- Using the toilet.
- Nose blowing.

Handwashing technique: this procedure need not take more than 30 seconds:
- Wet hands under running water before applying cleansing agent.
- Wash hands thoroughly, ensuring that all areas are covered, especially between fingers, around wrists, thumbs, palms, finger tips and under rings (Figure 4).
- Rinse well under running water and dry thoroughly on disposable paper towels.
- When decontaminating hands using an alcohol handrub, hands should be free of dirt and organic material. The handrub solution must come into contact with all surfaces of the hand. The hands must be rubbed together vigorously, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers, until the solution has evaporated.
- Jewellery: remove all wrist and ideally hand jewellery at the beginning of each shift.

Patient-care equipment
The equipment section of the Healthcare Cleaning Manual (DoH 2004a) contains guidelines to assist with the cleaning and decontamination of blood and bodily fluid spillages involving patient equipment. It was compiled by infection control members of the manual’s advisory group. Further specific details should be accessed through the policies and procedures of individual trusts.
Figure 4. Handwashing technique

1. Palm to palm
2. Right palm over left back and left palm over right back
3. Palm to palm fingers interlaced
4. Backs of fingers to opposing palms with fingers interlocked
5. Rotational rubbing of right thumb clasped in left palm and vice versa
6. Rotational rubbing backwards and forwards with clasped fingers of right hand in left palm and vice versa
member of the ward team, rather than a member of the cleaning-services team. The responsibility for other forms of cleaning may be the responsibility of the estates department. It is important that responsibilities are clear and well documented. A form for this purpose is included in the Healthcare Cleaning Manual (DoH 2004a).

Box 2 provides a summary of points for consideration prior to decontamination of patient care equipment.

Decontamination of blood and body-fluid spillages:

I Spillages of blood and bodily fluids in clinical areas must be decontaminated promptly. Dilution is the most important element in cleaning up spillages on the hospital ward. This is usually undertaken by the nursing team caring for the patient. However, there is no reason why appropriately trained domestic staff could not undertake this task as they do in non-clinical areas.

I Disposable gloves and an apron must be worn for cleaning the spillage and these should be disposed of in a clinical-waste bag after use.

I For a minor spillage, the surface should be disinfected using 1% sodium hypochlorite solution (10,000 ppm available chlorine).

I Larger spillages of blood can be absorbed using chlorine-based granules sprinkled directly onto the spillage.

I Remove waste and place content into a clinical-waste bag.

I The area should then be thoroughly cleaned with a general purpose detergent (refer to appropriate cleaning procedure) and dried.

I Wash hands thoroughly with soap and water after the removal of protective clothing.

Managers must ensure that staff performing decontamination duties receive training appropriate to the equipment and practices within individual departments. Inadequately trained staff may fail to decontaminate equipment appropriately, thus placing patients or other staff at risk. They may also risk their own health and safety if they are unaware of safe practice standards.

All staff involved in the use, maintenance and decontamination of medical devices must be appropriately supervised and their performance monitored. Appropriate risk assessments must be carried out prior to the decontamination of equipment and the use of chemicals. The local infection control team should provide specialist advice for the decontamination of equipment prior to purchase and during use. The choice of cleaning materials and cleaning chemical products must be discussed with the local infection control team.
granules on urine as this will result in the release of toxic fumes.

I. Absorb spillages of urine and faeces using paper towels and place into a clinical-waste bag for incineration. Wash the area with detergent and hot water. It may be necessary to follow with a disinfectant – consult your local infection control procedure.

The infectious agent associated with transmissible spongiform encephalopathies (TSEs) is unusually resistant to inactivation techniques. In the event of a spillage, seek advice from the infection control team.

Occupational exposure to blood or blood-stained body fluids

Standard infection control precautions, as previously illustrated, should be followed for inoculation injuries, and to clear up spillages on the ward - including spillages of blood and cerebrospinal fluid (CSF). Potentially infectious materials should be removed using absorbent material, and any waste, including cleaning tools such as mop-heads, should be disposed of as clinical waste in line with locally approved arrangements. Disposable gloves and an apron should be worn when removing such spillages and disposed of in line with locally approved arrangements. For further information please refer to your local blood-exposure policy.

Chemical spills must be managed according to COSHH risk assessment.

Processes of decontamination

The three processes of decontamination commonly used are:

Cleaning
A process that physically removes contamination but does not necessarily destroy microorganisms. The reduction of microbial contamination is not routinely measured and will depend upon many factors, including the efficiency of the cleaning process and the initial bioburden (the amount of organic matter in the environment). Cleaning removes micro-organisms and the organic material on which they thrive. To decontaminate patient equipment effectively, all organic debris – such as blood, tissue and other body fluids – must be removed from the item before disinfection or sterilisation. Effective cleaning of patient equipment before disinfection or sterilisation is of vital importance in reducing the risk of transmission of infectious agents.

Disinfection
A process used to reduce the number of viable micro-organisms, but which may not necessarily inactivate some microbial agents such as certain viruses and bacterial spores. Disinfection may not achieve the same reduction in microbial contamination levels as sterilisation.

Sterilisation
A process used to render an object free from micro-organisms, including viruses and bacterial spores. Normal sterilisation methods will not destroy prions.

Choosing the method of decontamination

The choice of decontamination method may be related to the infection risk associated with the intended use of the equipment. Other factors that must be considered include:

- The nature of the contamination.
- The time required for processing.
- The heat, pressure, moisture and chemical tolerance of the object.
- The availability of the processing equipment.
The quality and risks associated with the decontamination method.

The manufacturer's guidance.

Table 2 (pages 19-25) provides guidance for the preferred methods of cleaning patient equipment.

**Single-use devices:**
- Any device deemed unsuitable by the manufacturer for re-processing. Such products will be labelled with the words ‘single use’ or other synonymous reference, and will be marked with the symbol shown in Figure 3 (BSI 1997).
- Users who disregard this information and prepare single-use products for further use will be transferring legal liability for the safe performance of the product from the manufacturer to themselves or their employers.

Decontamination of equipment prior to service or repair:
- Anyone who inspects services, and anyone who repairs or transports medical devices and equipment, has a right to expect that he or she has been appropriately treated so as to remove or minimise the risk of infection or other hazards – for example, chemical or radiation.
- Wherever possible, medical devices should be decontaminated and all devices presented for service or repair must be provided with a decontamination certificate according to the local procedure.
- Refer to the Medical Devices Agency (MDA) document *Management of Medical Devices* (DoH 2003) before repair service or investigation.

**Re-assembly:**
- It is essential that equipment and devices are correctly re-assembled following decontamination, making use of the manufacturer's guidance. Staff must be adequately trained to be able to disassemble and re-assemble equipment and to check that it is operating normally before re-use.

**Health and safety**

*Health and Safety at Work Act 1974*

This act places a legal responsibility on everyone to work in a way that is safe, and to ensure risk is controlled as far as is reasonably practicable. Employees, contractors and members of the public, including patients, are covered by the act and should not be exposed to any health and safety risks by the operation of the healthcare building. The act also states that all employees who are working within the organisation at all times take reasonable care of themselves and others. Employees are responsible for abiding by their organisation's health and safety policies and procedures.

**Legislation**

All members of the cleaning services team have responsibilities to conform to and respect all aspects of health and safety legislation. Managers have a key responsibility to ensure that their departments function within the parameters of health and safety legislation and that staff are trained and assessed in these issues. Staff have a responsibility to make sure that they follow instructions in accordance with the cleanliness booklet.
local policy and do not place themselves or others in danger. Ward staff involved in supervising or monitoring cleaning services should refer to the Healthcare Cleaning Manual (DoH 2004a) for guidance.

Control of Substances Hazardous to Health (COSHH) 2002

The aim of COSHH is to reduce exposure to hazardous substances to acceptable levels to minimise health risks:

I COSHH is an integral part of each trust’s health and safety policy.
I All trusts should have conducted a suitable assessment of the risks from hazardous substances, including infection risk.
I The COSHH regulations require that organisations must have safe systems of working. Safety-data sheets and product-handling sheets must be provided for all products by the respective companies. This information must be assessed by the manager.
I A register of substances, with the completed assessment sheets, should be made available for staff.
I It is the responsibility of the manager to ensure that all staff in the cleaning services department are aware of, and understand, the COSHH policy, having been instructed and trained in the procedures and protocols detailed in this document relating to handling hazardous substances.

Summary COSHH information relating to the day to day chemicals used within the cleaning-services department should be available locally in each functional area.

Conclusion

A clean environment is an essential part of care – it is not an ‘add-on’. Nurses have a central role to play in keeping patient care areas clean and tidy, and in setting standards for their ward or department. However, nurses cannot deliver cleanliness in isolation. Cleaning a ward appropriately is a skilled task that demands an understanding of what, how and when to clean. The most essential thing that nurses can do is to develop a good relationship with those who have that expertise – the cleaners, housekeepers and managers who can make an important and necessary difference to the wellbeing of patients.
### Table 2. Preferred methods of cleaning patient equipment

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Preferred method</th>
<th>Additional recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arm rests</td>
<td>Wash with general purpose detergent (refer to manufacturer's instructions), rinse and dry</td>
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</tr>
<tr>
<td>Audiometer</td>
<td>Wipe with general purpose headphones detergent (refer to manufacturer's instructions) and dry. Disinfect surface with alcohol wipe</td>
<td></td>
</tr>
<tr>
<td>Baby changing</td>
<td>Wipe with general purpose mats detergent (refer to manufacturer's instructions) rinse and dry, then wipe with alcohol wipe</td>
<td></td>
</tr>
<tr>
<td>Baby scales</td>
<td>Wash with general purpose detergent</td>
<td></td>
</tr>
<tr>
<td>Bath hoist</td>
<td>Wash with general purpose detergent or bath/wash-basin/shower/bidet/cleaner (refer to manufacturer's instructions) or general surface cleaner, rinse and dry. Pay particular attention to connecting parts. If material, launder according to manufacturer's instructions. Disinfect surface with an alcohol wipe</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Equipment</th>
<th>Preferred method</th>
<th>Additional recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed frames</td>
<td>Wash with general purpose detergent and cradles (refer to manufacturer's instructions)</td>
<td></td>
</tr>
<tr>
<td>Bedpans, bedpan carriers</td>
<td>Washer-disinfector or use disposables. After washing bedcarriers, wash carriers for disposable pans with pan holders, disinfect storage racks with general purpose detergent (refer to manufacturer's instructions) and dry with alcohol wipe.</td>
<td></td>
</tr>
<tr>
<td>Blood pressure equipment</td>
<td>Wash or wipe with general purpose detergent (refer to manufacturer's instructions) and dry. Consider using disposable cuff for infectious patients.</td>
<td></td>
</tr>
<tr>
<td>Bowls (washing)</td>
<td>Wash with general purpose detergent Infected patients must rinse and dry thoroughly before disinfect on discharge.</td>
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</tr>
<tr>
<td>Breast pumps</td>
<td>Single-patient use accessories should be washed between uses with general purpose detergent, rinsed and dried. Wipe machine accessories with general purpose detergent (refer to manufacturer's instructions) and dry. Accessories to be sent to social services department on patient discharge.</td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Preferred methods of cleaning patient equipment
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<table>
<thead>
<tr>
<th>Equipment</th>
<th>Preferred method</th>
<th>Additional recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commodes</td>
<td>Wash with general purpose detergent</td>
<td>Wipe with alcohol (refer to manufacturer's instructions), wipe. Pay particular attention to arm rests and under the rim; clean from top to bottom taking care to get into all ridges.</td>
</tr>
<tr>
<td>Crockery and cutlery</td>
<td>Machine-wash; heat-disinfect above 80˚C and dry.</td>
<td>Hand-wash with hot water and general purpose detergent and air dry.</td>
</tr>
<tr>
<td>Intravenous stands</td>
<td>Wash with general purpose detergent (refer to manufacturer's instructions) and dry.</td>
<td></td>
</tr>
<tr>
<td>Examination couch</td>
<td>Wipe with general purpose detergent (refer to manufacturer's instructions) and dry.</td>
<td>Wipe with an alcohol wipe.</td>
</tr>
<tr>
<td>Flower vases</td>
<td>Wash with general purpose detergent, rinse and dry.</td>
<td></td>
</tr>
<tr>
<td>Furniture and fittings</td>
<td>Damp dust with general purpose detergent (refer to manufacturer's instructions).</td>
<td>Wipe with 10,000 ppm available chlorine.</td>
</tr>
</tbody>
</table>

Continues over page..
<table>
<thead>
<tr>
<th>Equipment</th>
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<tbody>
<tr>
<td>Hairdressing</td>
<td>Allocate to a patient and discard on discharge</td>
<td>Consider communal shaver (patient's own: heads only) no action</td>
</tr>
<tr>
<td>Infant</td>
<td>Wash with general purpose detergent and dry</td>
<td>Wipe with disinfectant as per local policy if baby has an infection</td>
</tr>
<tr>
<td>Infusion pumps</td>
<td>Wipe with general purpose detergent and dry</td>
<td>Wipe with alcohol wipes</td>
</tr>
<tr>
<td>Locker-tops</td>
<td>See 'furniture and fittings'</td>
<td></td>
</tr>
<tr>
<td>Mattresses</td>
<td>Wash impermeable cover, wash with general purpose detergent, rinse and dry</td>
<td>Available chlorine if contaminated or disposable wipe. Do not disinfect unnecessarily as this may damage the cover. For special mattresses follow manufacturer's instructions</td>
</tr>
<tr>
<td>Equipment</td>
<td>Preferred method</td>
<td>Additional or site recommendations</td>
</tr>
<tr>
<td>----------------------------</td>
<td>-----------------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Medicine pots, spoons etc</td>
<td>Discard after single use</td>
<td></td>
</tr>
<tr>
<td>Mop-heads</td>
<td>Dust control – discard after use</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IDamp mopping – launder after use, or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>discard (see local policies)</td>
<td></td>
</tr>
<tr>
<td>Moving and handling aids</td>
<td>Disposable slings are available</td>
<td></td>
</tr>
<tr>
<td>Nail brushes</td>
<td>Single use</td>
<td></td>
</tr>
<tr>
<td>Pillows</td>
<td>Treat as mattresses</td>
<td></td>
</tr>
<tr>
<td>Razors (safety)</td>
<td>Disposable</td>
<td></td>
</tr>
<tr>
<td>Razors (electric)</td>
<td>Use disposable heads</td>
<td></td>
</tr>
<tr>
<td>Sputum</td>
<td>Use disposable only</td>
<td></td>
</tr>
<tr>
<td>Toilet seats</td>
<td>Wash with general purpose detergent</td>
<td>After use by infected patient or if</td>
</tr>
<tr>
<td></td>
<td></td>
<td>grossly and dry contaminated, wash,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>rinse and dry. Wipe with 10,000 ppm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>available chlorine</td>
</tr>
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<tr>
<td>Tooth mugs</td>
<td>Disposable</td>
<td></td>
</tr>
<tr>
<td>Toys and play</td>
<td>Wash with general purpose detergent (refer to manufacturer's instructions) and soft toys should be dry, but do not soak soft toys. If destroyed.</td>
<td>Expensive contaminant can withstand low temperature steam.</td>
</tr>
<tr>
<td>Trolley tops</td>
<td>Clean with general purpose detergent (refer to manufacturer's instructions) and wipe dry</td>
<td></td>
</tr>
<tr>
<td>Urinals</td>
<td>Use washer-disinfector or use disposables</td>
<td></td>
</tr>
<tr>
<td>Ventilator</td>
<td>Damp dust daily (mechanical)</td>
<td></td>
</tr>
<tr>
<td>Walking aids</td>
<td>Wash with general purpose detergent (refer to manufacturer's instructions) and dry</td>
<td>If used by an infected patient.</td>
</tr>
<tr>
<td>Wheelchairs</td>
<td>Wash with general purpose detergent (refer to manufacturer's instructions) and wipe with alcohol (refer to manufacturer's instructions) and dry wipe after washing</td>
<td></td>
</tr>
</tbody>
</table>
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<tr>
<td>Weighing scales</td>
<td>Wash with general purpose detergent (refer to manufacturer's instructions) and dry</td>
<td></td>
</tr>
<tr>
<td>TV and handset</td>
<td>Damp dust with general purpose detergent, Wipe with clean equipment (refer to manufacturer's instructions); alcohol wipes in switch off, do not over-wet, and allow to line with local dry before use policies</td>
<td></td>
</tr>
</tbody>
</table>

Note: This list is not intended to be exhaustive. Each area should identify any other equipment and write cleaning instructions which should be agreed with the infection control team.

REFERENCES


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